THE ALLIANCE

A newsletter brought to you by CHPA - Community Health Provider Alliance

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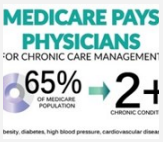

Chronic Care Management Services / Complex Care Management

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Other Things we're reading/ Listening to

2017 MSSP e- Clinical Quality Measures Submitted!

Congratulations CHPA MSSP'ers! You have successfully submitted your 2017 CMS Quality Measures! We want to thank CCMCN's formidable Measure Analyst-guru Michael Feldmiller for his assistance utilizing the Azara platform data to pull these measures and submit them to CMS. The measure set for MSSP is a CMS-provided sample of the actual attributed population, not the entire population. CHPA will be reviewing our interim results and discussing them at May's Triannual meetings. If you cannot join us there, we will be releasing ACO-level reporting after that time. CCMCN is also working on incorporating these measures into Azara's existing measure pool to report out on the FQHC level to monitor performance. CHPA would like to thank all of our ACO participants for their cooperation on the data submission in 2017 and looks forward to continued performance improvement!

The 2018 Quality Measures for MSSP Summary will be released later this month. If you are excited to read more about this, they are located here: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/2018-reporting-year-narrative-specifications.pdf

2017 MSSP ACO CAHPS Update

The 2017 MSSP ACO CAHPS data collection period ended February 1, 2018. CHPA's CMS-approved vendor, Press Ganey has submitted the ACO CAHPS and MIPS CAHPS results to CMS in accordance with the CMS data submission deadlines. The average patient response rate for Press Ganey's ACO CAHPS administration based on the 2017 performance year is 35.35%. The unofficial Press Ganey ACO CAHPS Summary Reports will be available in April 2018. The official ACO CAHPS and from CMS will likely be available in the fall of 2018. To view 2017/2018 Early Findings click here.

The 2018 version of the MSSP ACO CAHPS survey will likely be shorter and less comprehensive than previous years. Stay tuned as CMS finalizes the survey!

MSSP Attribution Files

CHPA has released 2018 MSSP Attribution files over Q1 of 2018. These files were sent to the clinical contacts, plus other specified contacts as requested by the clinics. These lists are crucial to MSSP success in 2018! These lists not only contain information about who your patients are, but also the chronic conditions they have, and their "ER frequent flyer" utilization. If you would like a personal training session or have questions regarding your list, please contact Erin Rager at erager@chpanetwork.com

MSSP Attribution Files cont.

Every 6 months, recheck for dropped HCCs, no visits, no AWV

Patient	Age Cat	E SRD RAF	DI SAB RAF	AGED DUAL RAF	AGED RAF	ER Freq Flyer (>=8 in 1st 9 months of 2017)	High Cost Bene Ind.	High Cost Bene (Costliest Dx)	Last PCP Visit	FQHC Name	Death Date	HCC Desc1	HCC Desc2
John Doe	65		0.307			ER FF	High-Cost	CKD	9/27/17	SMPL			
Jane Doe	65		0.658						9/27/17	SMPL		57-Schizo-phrenia	

What's next?

Please review this list and schedule these folks for their Annual Wellness Visit. Also, please note any patient without a PCP visit, or patients who flag as "ER Frequent Flyers".

CHPA Service Available for You: Commercial Contracting

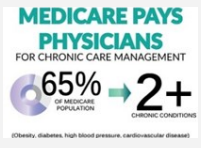
Did you know that CHPA offers commercial contracting services for our member FQHCs? Not only does CHPA work to bring shared savings and pay for performance opportunities, we love working with payers to gain Fee-for-service (FFS) contracts for our members. We have secured contracts with Aetna, Anthem, Bright Health, Cigna, Colorado Access, Multiplan, Rocky Mountain Health Plan, and United. Contact us today to find out how CHPA can help you with contracting plus these services:

- Contract Management and Advisement – assistance with understanding contracts, terminology, and other nuances specific to payer arrangements.
- Claims Resolution and Assistance with Payers
- MCO Reconciliation

CHPA Service Update: Credentialing

We've heard you! CHPA continues to discuss different mechanisms we can support credentialing resourcing efforts in your clinics. Please stay tuned over the next few months as we review different staffing, insourcing, outsourcing, and training models. In the meantime, don't forget to take advantage of CCHN Training and Technical Assistance offerings for credentialing & privileging training such as the training coming up this May that you may register for here: https://www.gifttool.com/registrar/ShowEventDetails?ID=2109&EID=25463

Chronic Care Management Services / Complex Care Management



New FQHC Care Management Services

Effective January 1, 2018, FQHCs can receive payment for psychiatric Collaborative Care Model (CoCM) services when 70 minutes or more of initial psychiatric CoCM services or 60 minutes or more of subsequent psychiatric CoCM services are furnished and G0512 is billed either alone or with other payable services on an FQHC claim. CCM services furnished on or before December 31, 2017 will continue to be processed and paid when CPT code 99490 is billed alone or with other payable services on an FQHC claim. Service lines reported with CPT code 99490 will be denied for dates of service on or after January 1, 2018.

Chronic Care Management Services / Complex Care Management (cont.)

Care Management Services in RHCs and FQHCs - FAQs - (Updated on 2/27/2018) [PDF, 212KB]

Excerpt: Care Management services are billed and paid as follows:

TCM: For TCM services furnished on or after January 1, 2013, TCM services are billed by adding CPT code 99495 (14-day discharge, moderate complexity) or CPT code 99496 (7 day discharge, high complexity) to an RHC or FQHC claim, either alone or with other payable services. If it is the only medical service provided on that day with an RHC or FQHC practitioner it is paid as a stand-alone billable visit. If it is furnished on the same day as another visit, only one visit is paid. 2018 payment (CPT code 99495 or 99496) - Same as payment for an RHC or FQHC visit

CCM: For CCM services furnished between January 1, 2016 and December 31, 2017, CCM services are billed by adding CPT code 99490 (20 minutes or more of CCM services) to an RHC or FQHC claim, either alone or with other payable services. Payment is based on the Physician Fee Schedule (PFS) national average non-facility payment rate for CPT code 99490. RHC or FQHC claims submitted using CPT code 99490 for services on or after January 1, 2018 will be denied. For CCM services furnished on or after January 1, 2018, CCM services are billed by 3 adding the general care management HCPCS code, G0511, to an RHC or FQHC claim, either alone or with other payable services. Payment is set annually at the average of the national non-facility PFS payment rate for CPT codes 99490 (20 minutes or more of CCM services), 99487 (60 minutes or more of complex CCM services), and 99484 (20 minutes or more of general behavioral health integration services).

2018 payment (HCPCS code G0511) – $62.28

General BHI: For general BHI services furnished on or after January 1, 2018, general BHI services are billed by adding the general care management HCPCS code, G0511, to an RHC or FQHC claim, either alone or with other payable services. Payment is set annually at the average of the national non-facility PFS payment rate for CPT codes 99490 (20 minutes or more of CCM services), 99487 (60 minutes or more of complex CCM services), and 99484 (20 minutes or more of general behavioral health integration services).

2018 payment (HCPCS code G0511) – $62.28

Psychiatric CoCM: For psychiatric CoCM services furnished on or after January 1, 2018, psychiatric CoCM services can be billed by adding the psychiatric CoCM G code, G0512, to an RHC or FQHC claim, either alone or with other payable services. Payment is set annually at the average of the national non-facility PFS payment rate for CPT codes 99492 (70 minutes or more of initial psychiatric CoCM services) and CPT code 99493 (60 minutes or more of subsequent psychiatric CoCM services).

2018 payment (HCPCS code G0512) – $145.08

Collide or Collaborate? Community health centers and hospitals work through their overlap

Modern Healthcare, February 2018

Susanna Luthi

AltaMed, a Southern California health system, has a storied beginning. In the 1960s, volunteer physicians and nurses served patients out of an East Los Angeles barrio clinic, where they kept a 5-gallon water jug to collect any spare money people could offer.

"We've come a long way from a free clinic in the 1960s, then to a clinic of last resort, to where we are today—a provider of choice," said Cástulo de la Rocha, AltaMed's CEO.

Today, AltaMed employs a workforce of nearly 3,000 and operates 50 clinics extending from Los Angeles to Orange County. It serves roughly 300,000 patients annually. Soon, AltaMed will also be licensed to run its own health plan—in actuarial terms, to assume full risk. AltaMed does it all. This Southern California medical powerhouse also happens to be a federally qualified health center.

Despite humble beginnings, federally qualified health centers, known as FQHCs, have become a sleeping giant in the healthcare industry. Amid this transformation, hospitals—particularly in rural or otherwise underserved areas—find themselves stepping carefully in an uneasy dance with primary-care focused health centers. Follow the money. Underlying the relationship is increased competition for the same patient population. ***Over the past three decades, Medicare, Medicaid and commercial insurance have become the dominant payers of community health centers' patients.*** While this is in no way indicative

of the general market, one insurance carrier reported FQHCs accounted for 90% of its primary-care business, said a policy analyst speaking on background.

At the same time, health centers have proliferated. Today, nearly 1,400 community health centers with their network of 10,000-plus sites serve about 26 million people. Congress recently appropriated more than $7 billion over two years to replenish the lapsed funding that pushed more vulnerable community health centers into financial panic. But they aren't as dependent now on the appropriation as they were in 1985, when 83% of a federally qualified health center's revenue came from the federal grant. Back then, Medicaid patients accounted for only 7% of a health center's funding and Medicare patients for just 1%. By 2015, the federal grant represented just 18% of an average health center's funding compared with Medicaid at 44%. Medicare accounted for 7% and other sources, including commercial insurance, accounted for 19%, according to data from consulting firm FQHC Germane, which advises community health centers on business development, grant writing and other areas.

Steve Weinman, vice president of the firm, has worked for decades in health centers in his home state of Florida and tracked the on-the-ground story behind the statistics. As he puts it, "We started out loosey-goosey and rarely charged anything, didn't worry about anything beyond our grant funding." That's far from the case now. ***Community health centers' transition from being mostly humble clinics to big business was born out of their need to survive in an increasingly complex and expensive healthcare landscape as well as the constant demand for care,*** Weinman said.

Yet as hospitals have learned, competition for patients also leads to competition across service lines. ***Some community health centers offer the same ancillary services as local hospitals, such as imaging and lab work.*** Tim Moore, president of the Mississippi Hospital Association, said he doesn't question the need for health centers to compete for patients with a payer behind them, but his members are feeling the tug. "When hospitals, particularly small rural hospitals, are being strapped so hard for revenue, and you're trying to determine how to keep your doors open, if you lose any kind of service that brings revenue into the hospital, it's difficult, it exacerbates the problem," Moore said. In conversations with hospital and community health officials, similar points of friction emerged nationwide.

One criticism of community health centers from physicians is the underlying federal statute, which set in place a fee-for-service Medicaid payment model. By law, community health centers receive cost-based prospective payments even if their state uses capped payments for Medicaid. California, for example, reimburses FQHCs for the difference between the managed-care plan's payment and the federal fee-for-service rate. California manages this wraparound payment through what both state officials and providers call a burdensome reconciliation process at the end of each year.

Some view the prospective payments as driving poor management of patients' care. Dr. Michael Hochman, an assistant professor at the USC Keck School of Medicine, wants to see FQHCs embrace a value-based model like AltaMed, where he used to work. "With fee-for-service, it's all about getting the Medicaid patients," Hochman said. "If patients are going elsewhere, that's less money for the FQHC."

This can lead to over-scheduling of unnecessary visits for patients. As long as they get reimbursed by Medicaid, these often extraneous appointments can be lucrative for health centers, particularly in managed-care states since at the end of the process they will get the extra boost in payment. Meanwhile, Hochman said, hospitals can't compete for those Medicaid patients on the same level because their reimbursement rate is much lower without the advantage of the prospective payment system.

But then there's the consideration of rural community health centers operating in a healthcare desert on razor-thin margins. In states with low Medicaid reimbursements but a majority of Medicaid patients—and in towns where a health center may be the only provider—the prospective payment is a lifesaver. In states that didn't expand Medicaid under the Affordable Care Act, the prospective payment can be even more crucial.

While alternative payment models would allow community health centers to combine services for a patient during one visit, policymakers would need to make adjustments so a critical part of the healthcare safety net isn't jeopardized, said Rachel Tobey, director of the research group John Snow. Tobey, with USC Keck's Hochman, has been involved in California's attempts to move community health centers to an alternative payment model. "Once you open the door for states to waive PPS protections, if you open it even a crack, you run the risk of driving important safety-net providers out of business," Tobey said.

Collide or Collaborate? Community health centers and hospitals work through their overlap (cont.)

Both community health centers and hospitals can take issue with how mergers happen. Sometimes hospitals acquire community health centers to use as their referral centers or to compete with larger FQHCs.

As AltaMed's de la Rocha said, "Now I have hospitals opening FQHCs to compete with me." Or the friction may happen within the community health center sphere. Competition between FQHCs takes many forms, with some clinics blocking new entities from entering a market. Elsewhere, the clinics collaborate just fine.

Just as the payer mix is forcing increased competition, it may also be the very thing that spurs collaborations as government payments increasingly reward coordination. As the consultant Weinman said, health centers have to adapt in order to win the Medicaid managed-care contracts in the first place. "We need to compete for large contracts with large providers that will take the payers and send everyone who can't pay to the community health centers," he said. Moore is trying to move past the stalemate of competition and into the hard work of next steps, including solving Mississippi's healthcare access problems.

"We've tried to get away from competition and hit the restart button," Moore said. So last year he assembled a coalition of community health centers and hospitals to start a residency program for a specialty-care physician that a single rural provider couldn't afford alone. Moore sees this first collaboration blossoming into support for resident clinicians across various medical disciplines like obstetrics and behavioral health. This kind of effort could bolster the state's entire healthcare system, he said.

"Let's bring the FQHCs and rural hospitals together, let's work together and share the cost and expense, share the patients in order for physicians to come to Mississippi," Moore said. Moore isn't alone in thinking this way.

In rural North Dakota, critical-access hospital Sakakawea Medical Center and a community health center essentially linked arms under a shared CEO in 2011.

"Prior to 2011, there was a very competitive relationship between two organizations," said Derrold Bertsch, who heads both the hospital and health center. The unlikely collaboration happened when the health center was without a CEO and asked Bertsch to come in. Now the two organizations continue to operate as separate not-for-profits with separate governing boards, but they share a few board members and each doesn't offer services that the other facility can do better.

For Bertsch, any solution needs to start local. "It's incumbent upon rural FQHCs and critical-access hospitals and their leadership to develop those solutions," he said. As community health centers grow and expand and potentially build collaborations with hospitals, it's unclear how they will fit into a broader landscape that is in the midst of a consolidation frenzy. But it's something Moore and others are thinking about.

"In my mind, the role of the small rural hospital is going to look more like the FQHC than it does today," Moore said. "We will be moving away from acute beds in small rural hospitals. It's just not sustainable, and we all know that."

De la Rocha said he also sees an increasingly symbiotic relationship between the two. Dr. Ilan Shapiro, AltaMed's medical director of health and wellness, helps oversee care at the system's 50 clinics. AltaMed includes a pediatric clinic attached to Los Angeles Children's Hospital, with whom it partners, and it operates the third-largest Medicare Program of All-Inclusive Care for the Elderly (PACE) in the country—the largest in California.

"From my own standpoint, we have something hospitals need," he said. "We have a healthcare delivery system that has facilities and clinics in communities where hospitals aren't located," de la Rocha said.

The crucial impact on patients happens in the communities, he added, whether it's managing their diabetes or hypertension. Likewise, health centers need the hospitals' institutional care.

However the future looks, Hochman said he wants to jettison the community health center model of a separate safety net and move to a merged system where everyone is treated the same way.

"There's a distinction between safety-net provider and commercial providers—essentially two levels of care," he said. "But 1 out of 5 people are now on Medicaid. Why set up a whole different system for people on Medicaid?"

As community health centers move away from their safety-net role, that dream may be in sight.

Other Things we're reading/Listening to

HRET HIIN recently released two new physician related podcasts.

The topic for the first podcast is *Physician Activation and Participation in Quality Improvement Activities.* Dr. Bruce Spurlock from Cynosure Health facilitates a discussion with Dr. Gary Roth, Chief Medical Officer of Michigan Health and Hospital Association about approaches that are most effective to align physician priorities with the hospital's quality improvement agenda. Dr. Roth highlights the importance of identifying a physician champion and optimizing data to increase involvement.

The second podcast titled *Physician Engagement Activation in Hospital Quality & Safety Programs*, provides methods to activate physicians in hospital quality and patient safety programs within rural critical access settings. Listen to Dr. Bruce Spurlock from Cynosure Health facilitate a discussion with Dr. Jason Cohen, Chief Medical Officer from North Valley Hospital in Whitefish, Montana. The discussion focuses on building a culture of participation, designating physician leaders, and creating common goals among staff. Be sure to share these podcasts with your hospital quality improvement leaders and visit the HIIN Physicians page for additional physician related activities.

Community Health Provider Alliance (CHPA) is an accountable care organization formed around a statewide integrated system of federally-qualified Community Health Centers (CHCs). CHPA was formed to improve care transitions and implement best practices in patient-centered medical home care coordination, to develop alternative payment methodologies and payment reform to decrease overall healthcare costs, and increase patient satisfaction.

If you would like to be added to the newsletter e-mail distribution list, please contact Jake Rosse, CCHN executive assistant, at jake@cchn.org or (303) 867-9546.

If you have questions about the content of this newsletter, please contact Erin Rager at erager@chpanetwork.com

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